Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

August 7, 2001

CIN: A-02-00-01023

Ms. Rhona Hetsrony
Executive Director
Hillside Hospital
North Shore-Long Island Jewish Health System
75-59 263 Street
Glen Oaks, New York 11004

Dear Ms. Hetsrony:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Medicaid Outpatient Psychiatric Services Provided by Hillside Hospital, North Shore - Long Island Jewish Health System for Fiscal Year Ended September 30, 1999." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determinations as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to Common Identification Number A-02-00-01023 in all correspondence relating to this report.

Sincerely yours,

James P. Edert
for Timothy J. Horgan
Regional Inspector General
for Audit Services

2 Enclosures

Direct Reply to HHS Action Official:

Mr. Peter Reisman
Associate Regional Administrator
Division of Financial Management
Centers for Medicare and Medicaid Services, Region II
U.S. Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY HILLSIDE HOSPITAL, NORTH SHORE - LONG ISLAND JEWISH HEALTH SYSTEM FOR FISCAL YEAR ENDED SEPTEMBER 30, 1999

AUGUST 2001
A-02-00-01023

Office of Inspector General

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Department of Health and Human Services

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

EXECUTIVE SUMMARY

Background

The Medicaid program covers outpatient hospital services, physician services, clinic services, and prescription drugs pursuant to an approved State program. The Federal government and the States share in the cost of the program. In New York State (NYS), the Federal share is 50 percent. The NYS Medicaid requirements cover outpatient programs for adults with a diagnosis of mental illness and children with a diagnosis of emotional disturbance.

Objective

The objective of our review was to determine whether psychiatric services rendered on an outpatient basis were billed for and reimbursed in accordance with Medicaid requirements.

Summary of Findings

During Federal Fiscal Year (FY) ended September 30, 1999, Hillside Hospital, North Shore - Long Island Jewish Health System (Hospital) received reimbursement for 64,520 Medicaid outpatient psychiatric claims totaling $8,490,735 (Federal share $4,245,267). To determine whether controls were in place to ensure compliance with Medicaid regulations and guidelines, we reviewed the medical and billing records for 100 statistically selected claims totaling $13,543 (Federal share $6,771). These claims were made on behalf of patients who received services in the Hospital's outpatient psychiatric department.

Generally, we found that the Hospital received reimbursement for claims that were reasonable, necessary, and adequately supported by medical records. However, our analysis showed that $1,720 (Federal share $860) of the sampled claims did not meet Medicaid criteria for reimbursement. Claims found unallowable were for services with insufficient treatment plans or not properly supported by medical record documentation.

We found for the most part the Hospital had adequate procedures for the proper billing of Medicaid outpatient psychiatric services. However, in limited instances, procedures were not established. In addition, staff did not always follow existing Hospital procedures.

We extrapolated our sample results to the population of claims at the Hospital during FY 1999 and estimated that the Hospital was overpaid by Medicaid $638,260 (Federal share $319,130).

Recommendations

We recommend that the Hospital strengthen its procedures to ensure that claims for outpatient psychiatric services are properly documented in accordance with Medicaid regulations. In addition, we recommend the Hospital refund $638,260 (Federal share $319,130) to Medicaid. Accordingly, we will share this report with NYS Department of Health (DOH) so that it can monitor the recovery of the overpayment.

In response to our draft report (see APPENDIX B), the Hospital agreed that documentation for 11 of the 14 disallowed sample claims was technically incomplete, but believed that the services reviewed were rendered, documented, and reasonable and necessary. For the remaining three claims, the Hospital acknowledged that the claims were not in compliance with Medicaid regulations concerning physician signature on the treatment plan. In addition, the Hospital agreed to strengthen its procedures to ensure that claims for outpatient psychiatric services are properly documented. Based on comments made by the Hospital and reviewed by the medical reviewers, we believe that our final audit determinations are correct and no further adjustments to our report are necessary. The basis for our position is discussed starting on page 9 of this report.

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INTRODUCTION

Background

The Medicaid program, established by Title XIX of the Social Security Act (the Act), is a cooperative venture jointly funded by the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America=s poorest people. The Centers for Medicare and Medicaid Services (CMS)[1] has issued general regulations for the Medicaid program.

Within the broad national guidelines provided by CMS, each of the States: (1) establishes its own eligibility standards, (2) determines the type, amount, duration, and scope of services, (3) sets the rate of payment for services, and (4) administers its own program.

New York initiated its Medicaid program on May 1, 1966. The NYS DOH is the Single State Agency for Medicaid. The DOH delegates certain of its responsibilities to other State agencies. One such agency is the Office of Mental Health (OMH), which is responsible for the overall administration of inpatient and outpatient psychiatric services.

Title XIX of the Act requires that in order to receive Federal-matching funds, certain basic services must be offered to the categorically needy population in any State program. Outpatient hospital services and physician services are included in the required basic services. Many states also include clinic services and prescribed drugs as optional services covered under the Medicaid program.

The amount of total Federal outlays for Medicaid has no set limit; rather, the Federal government must match whatever the individual State decides to provide, within the law, for its eligible recipients. The FY 1999 Federal share for New York State Medicaid services was 50 percent. Providers participating in Medicaid must accept Medicaid payment rates as payment in full.

The Code of Federal Regulations at 42 CFR 482.1(a)(5) requires hospitals that receive payments under Medicaid to meet the requirements for participation in Medicare. Part 482.24 of the 42 CFR requires that a medical record be maintained for every individual evaluated or treated in a hospital.

Part 587 of Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York (14 NYSCRR) establishes and sets certification standards for six categories of outpatient programs: Clinic Treatment programs for Adults, Clinic Treatment programs for Children, Continuing Day Treatment, Day Treatment programs for Children, Intensive

[1] Prior to June 2001, the CMS was known as the Health Care Financing Administration (HCFA).

Psychiatric Rehabilitation Treatment, and Partial Hospitalization. Part 587 also provides treatment planning guidance for the programs, including:

- Treatment planning shall be based on an assessment of the recipient's psychiatric, physical, social, and/or psychiatric rehabilitation needs which result in the identification of the following: (1) the recipient's designated mental illness diagnosis, (2) the recipient's problems and strengths, (3) the recipient's treatment goals consistent with the purpose and intent of the program, and (4) the specific objectives and services necessary to accomplish goals.

  The treatment plan shall include, but need not be limited to, the following: (1) the signature of the physician involved in the treatment, (2) the recipient's designated mental illness diagnosis, (3) the recipient's treatment goals, objectives and related services, (4) plan for the provision of additional services to support the recipient outside of the program, and (5) criteria for discharge planning…A periodic review of the treatment plan shall include the following: (1) input of all staff involved in treatment of the recipient, (2) the recipient, his or her family and/or other collaterals, as appropriate, (3) assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan, (4) adjustment of goals, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate, and (5) the signature of the physician involved in the treatment. [14 NYSCRR Part 587.16]
- Progress notes shall be recorded by the clinical staff member(s) who provided services to the recipient. Such notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded within the following intervals: (1) Clinic treatment programs - each visit and/or contact, (2) Continuing day treatment programs - at least every two weeks, (3) Partial hospitalization programs - each visit and/or contact, (4) Day treatment programs - at least every week. [14 NYSCRR Part 587.16]

Part 588 of 14 NYSCRR establishes standards for reimbursement of outpatient programs for adults with a diagnosis of mental illness and children with a diagnosis of emotional disturbance, including:

- Reimbursement shall only be made for services identified and provided in accordance with an individual treatment plan or psychiatric rehabilitation service plan. [14 NYSCRR Part 588.5]

- For Clinic Treatment services, the treatment plan shall be developed prior to the fourth visit after admission or within 30 days of admission, whichever comes first. Review of the treatment plan shall be every three months, unless the individual is discharged and readmitted, in which case the review cycle begins again. [14 NYSCRR Part 588.6]

- For Continuing Day Treatment services, the treatment plan shall be completed prior to the twelfth visit after admission or within 30 days of admission, whichever occurs first. Review of the treatment plan shall be every three months. [14 NYSCRR Part 588.7]

- For Day Treatment services, the treatment plan required shall be completed within 30 days of admission. Review of the treatment plan shall be every three months. [14 NYSCRR Part 588.8]

- For Partial Hospitalization services, the treatment plan shall be completed prior to the fourth visit after admission. Review of the treatment plan shall be every two weeks. [14 NYSCRR Part 588.9]

- For Intensive Psychiatric Rehabilitation services, the psychiatric rehabilitation service plan shall be completed within five visits after admission. Review of the service plan shall be every month. [14 NYSCRR Part 588.10]

In NYS, Medicaid reimbursement is based on face-to-face encounters between clinical staff and patient(s) or collateral(s) for the provision of services identified and provided in accordance with a treatment plan and documented in the patient's record. For each program type, visits must meet a specified minimum duration to be billed. The date, type of service and duration must also be recorded in the case record.

Reimbursement is limited to one mental health program visit, not including crisis visits, and one collateral visit or group collateral visit per patient per day, regardless of the number of collaterals involved in the visit.

Hillside Hospital, the clinical division of North Shore-Long Island Jewish Health System, provides inpatient and outpatient psychiatric services. The six outpatient programs licensed by NYS OMH include: (1) Clinic Treatment Programs for Adults, (2) Clinic Treatment Programs Serving Children, (3) Continuing Day Treatment Program, (4) Day Treatment Programs Serving Children, (5) Partial Hospitalization Programs, and (6) Intensive Psychiatric Rehabilitation Treatment Programs. The Hospital is situated on the eastern border of New York City and primarily serves residents of Queens, Nassau and Suffolk counties.

Objective, Scope and Methodology

The objective of this audit was to determine whether outpatient psychiatric services were billed for and reimbursed in accordance with Medicaid regulations. Our review included services provided during FY 1999.

To accomplish our objective, we:

- Reviewed Medicaid criteria related to outpatient psychiatric services.
- Used computer programming to identify the universe of 64,520 claims valued at $8,490,735 (Federal share $4,245,267) from the Medicaid Management Information System.
- Employed a simple random sample approach to select a statistical sample of 100 outpatient psychiatric claims valued at $13,543 (Federal share $6,771).
- Interviewed appropriate Hospital administrative personnel to obtain an understanding of how the medical records were maintained and how outpatient psychiatric services were documented and billed.
- Performed detailed audit testing on the medical and billing records for the claims selected in the sample.
- Utilized medical review staff (a psychiatrist and registered nurses) at the Island Peer Review Organization to analyze the medical records supporting the claims.
- Used a variables appraisal program to estimate the dollar impact of improper claims in the total population.
- Discussed the audit methodology and results with officials from CMS, NYS DOH and NYS OMH.

We limited consideration of the internal control structure to those controls related to the submission of claims to Medicaid because the objective of our review did not require an understanding or assessment of the entire internal control structure at the Hospital. Our review was made in accordance with generally accepted government auditing standards. Our fieldwork was performed from May 2000 through October 2000 at the Hospital facilities located in Glen Oaks, New York, and at the Island Peer Review Organization located in Lake Success, New York.

The Hospital's response to the draft report is appended to this report (see APPENDIX B), and is addressed on page 9**.** We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

FINDINGS AND RECOMMENDATIONS

In FY 1999, the Hospital received reimbursement for 64,520 Medicaid outpatient psychiatric claims totaling $8,490,735 (Federal share $4,245,267). We reviewed the medical and billing records for 100 statistically selected claims totaling $13,543 (Federal share $6,771). In general, we found that the Hospital received reimbursement for claims that were reasonable, necessary, and adequately supported by medical records. However, our analysis showed that $1,720 (Federal share $860) of the sampled claims did not meet Medicaid criteria for reimbursement. Based on an extrapolation of the statistical sample, we estimate that the Hospital overstated its FY 1999 Medicaid outpatient psychiatric services by $638,260 (Federal share $319,130). We determined the unallowable claims were for services with insufficient treatment plans or not properly supported by medical record documentation.

The findings from our review of Medicaid outpatient psychiatric claims are described in detail below.

INSUFFICIENT TREATMENT PLANS

From our review of the medical records for the 100 outpatient psychiatric claims in our sample, we identified 13 claims totaling $1,602 for patients with insufficient treatment plans. Specifically, we determined five claims lacked current treatment plans, five claims had no physician signature, and two claims had insufficient discharge planning. Additionally, one claim was disallowed for two reasons; the treatment plan had no physician signature and lacked sufficient discharge planning.

Current Treatment Plans

Treatment planning is the process of developing, evaluating and revising an individualized course of treatment based on an assessment of the recipient's diagnosis, behavioral strengths and weaknesses, problems, and service needs. Treatment planning shall be an ongoing process carried out by the professional staff in cooperation with the recipient and his or her family and/or other collaterals, as appropriate, which results in a treatment plan. The treatment plan shall be updated or revised to document changes in the recipient's condition or needs and the services provided.

The time periods for developing initial treatment plans and subsequent reviews vary depending upon the program the patient is admitted into. Specifically, Part 588.6(g) of 14 NYSCRR requires that treatment plans for Clinic Treatment programs be developed prior to the fourth visit after admission or within 30 days of admission, whichever comes first. Subsequent review of the treatment plan shall be every three months. Part 588.7(d) requires that treatment plans for Continuing Day Treatment programs be completed prior to the twelfth visit after admission or within 30 days of admission, whichever occurs first. Subsequent review of the treatment plan shall be every three months. Part 588.8(d) requires that treatment plans for Day Treatment

programs serving children be completed within 30 days of admission. Subsequent review of the treatment plan shall be every three months.

Although we found that the Hospital's policies and procedures were consistent with State regulations, we determined that the Hospital did not always follow its existing procedures for preparing individualized treatment plans for each patient receiving ongoing psychiatric care. From our review of the medical records for the 100 outpatient psychiatric claims in our sample, we identified five claims totaling $690 for patients who had treatment plans that did not comply with Medicaid regulations concerning time periods for developing treatment plans. An example of an error found to be lacking a current treatment plan follows:

On December 18, 1998, the Hospital submitted a claim to Medicaid for a Day Treatment visit and received a reimbursement totaling $165. With assistance provided by the medical reviewers from the PRO, we determined the treatment plan was not reviewed within a timely manner.

> According to the medical reviewers, "Treatment plan dated 8/5/98, signed 7/30/98 noted to be 5-6 weeks outdated by date of service. Next treatment plan documented in chart dated 1/5/99. … Documentation does not meet reimbursement criteria due to outdated treatment plan."

Physician Signatures

Part 587.16(e) and (g) of 14 NYSCRR require the signature of the physician involved in the treatment to be included on the treatment plan and the periodic review of the treatment plan, respectively. We found that the Hospital's policies and procedures were consistent with these State regulations. However, we did identify five claims totaling $646 for patients who had treatment plans that were not signed by the treating physician. An example of an error found to be lacking the physician's signature on the treatment plan follows:

On February 24, 1999, the Hospital submitted a claim to Medicaid for a Children's Clinic visit and received a reimbursement totaling $118. With assistance provided by the medical reviewers from the PRO, we determined the physician, as required by Medicaid regulations, did not sign the treatment plan.

> According to the medical reviewers, "Treatment Plan reviewed 1/30/99, signed by CSW clinician however not signed by physician."

Therefore, we determined this claim to be improper. Similar omissions were noted for the other four claims determined to be improper due to lack of physician signatures.

Discharge Planning

Discharge planning is the process of planning for termination from a program or identifying the resources and supports needed for transition of an individual to another program and making the necessary referrals. Discharge planning includes linkages for treatment, rehabilitation and supportive services based on assessment of the recipient's current mental status, strengths, weaknesses, problems, service needs, the demands of the recipient's living, working and social environment, and the client's own goals, needs and desires.

Part 587.16(e) of 14 NYSCRR stipulates that the initial treatment plan shall include criteria for discharge planning. In addition, Part 587.16(g) of 14 NYSCRR requires periodic reviews of treatment plans to include intervention strategies or initiation of discharge planning, as appropriate.

We found that for the most part the Hospital had adequate procedures for ensuring that discharge planning was discussed on either initial treatment plans or periodic treatment plan reviews, as required by Medicaid regulations. However, discharge planning was absent from the Hospital policies and procedures manual for Adult Clinic program. In addition, the Hospital policies and procedures for the Children Clinic program only addressed discharge planning during the treatment plan review. Discharge planning was not mentioned in the Hospital policies and procedures developed for completing the initial treatment plan. When procedures were established, Hospital staff did not always follow these existing procedures.

We identified two claims totaling $148 for patients who had treatment plans that did not contain adequate discharge planning. An example of an error found to be lacking adequate discharge planning on the treatment plan follows:

On October 30, 1998, the Hospital submitted a claim to Medicaid for an Adult Clinic visit and received a reimbursement totaling $74. With assistance provided by the medical reviewers from the PRO, we determined that discharge planning was not sufficiently addressed in the treatment plan.

> According to the medical reviewers, "Treatment Plan dated 9/23/98, indicates N/A for discharge criteria. Chart does not document rationale for inability to document discharge criteria."

In addition, one claim totaling $118 was disallowed because the treatment plan had no physician signature and had insufficient discharge planning.

Without an up-to-date, physician-signed, proper treatment plan to identify the patient's diagnosis, problems and strengths, treatment goals, as well as objectives and services necessary to accomplish those goals, we could not determine with any certainty that the services were indeed reasonable and necessary.

SERVICES NOT SUPPORTED BY MEDICAL RECORDS

The 14 NYSCRR Part 587.16(f) requires progress notes be completed by the clinical staff member(s) who provided services. The notes shall identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes shall be recorded at each visit and/or contact for clinic treatment programs.

According to 42 CFR 482.24, the hospital must maintain a medical record for each inpatient and outpatient. The medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The medical records must be retained in their original or legally reproduced form for a period of at least 5 years. In addition, the medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Further, all records must document the following, as appropriate: (1) admitting diagnosis, (2) results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient, (3) all practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition, and (4) discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.

We identified one claim totaling $118 for a patient in which the medical record did not contain documentation supporting the service billed, as described below:

The Hospital submitted a claim to Medicaid and received a reimbursement totaling $118 for a Clinic Treatment visit on January 19, 1999. With the assistance of medical review personnel from the PRO, we determined there was no progress note for the date of service.

> The medical reviewers noted that "No progress note or clinical documentation provided for the visit billed 01/19/99."

Without complete medical record documentation, including a description of what took place in a therapy session, the patient's interaction with group members, his/her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the patient's level of care is unclear. Further, inadequate documentation of patient therapies and treatments provides little guidance to physicians and therapists to direct future treatment. In this regard, the lack of required documentation precluded us from determining whether those services were needed.

Conclusion

In FY 1999, the Hospital received reimbursement for 64,520 Medicaid outpatient psychiatric claims totaling $8,490,735 (Federal share $4,245,267). In general, our review showed that the Hospital received reimbursement for claims that were reasonable, necessary, and adequately supported by medical records. However, our audit of 100 statistically selected claims totaling $13,543 (Federal share $6,771), disclosed that 14 claims totaling $1,720 (Federal share $860) should not have been billed to the Medicaid program. Extrapolating the results of the statistical sample over the population using standard statistical methods, we are 95 percent confident that the Hospital was overpaid at least $638,260 (Federal share $319,130) for FY 1999. We attained our estimate using a single stage appraisal program. The details of our sample appraisal can be found in the APPENDIX A.

Recommendations

We recommend that the Hospital strengthen its procedures to ensure that claims for outpatient psychiatric services are properly documented in accordance with Medicaid regulations and guidelines. In addition, we recommend the Hospital refund $638,260 (Federal share $319,130) to Medicaid. Accordingly, we will share this report with NYS DOH so that it can monitor the recovery of the overpayment.

AUDITEE RESPONSE AND OIG COMMENTS

The Hospital, in its response (see APPENDIX B), expressed appreciation for the professionalism and responsiveness of the OIG audit team during the review process. The Hospital also recognized that a number of valuable recommendations were made regarding operational measures that can be taken to enhance and facilitate the Hospital's compliance with Medicaid reimbursement regulations.

The Hospital agreed that documentation for 11 of the 14 disallowed sample claims was technically incomplete, but believed that the services were rendered, documented, and reasonable and necessary. For the remaining three claims, the Hospital acknowledged that the claims were not in compliance with Medicaid regulations concerning physician signature on the treatment plan. In addition, the Hospital agreed to strengthen its procedures to ensure that claims for outpatient psychiatric services are properly documented. Furthermore, the Hospital described how it was currently implementing a comprehensive performance improvement program to enhance its efforts to maintain full compliance with all Medicaid billing and documentation requirements.

We have summarized the auditee's relevant responses and provided our comments below.

Auditee Response Regarding Current Treatment Plans

The Hospital acknowledged that for the five claims totaling $690, which lacked current treatment plans, the plans had been completed more than three months prior to the date of service and, therefore, the technical requirements of the Medicaid regulations were not met. However, the response indicated that the patients' treatment needs were reviewed regularly by the team of professionals involved in their care, as documented in progress notes.

OIG Comments on Current Treatment Plans

We reviewed the Hospital's response regarding current treatment plans. We disagree with the Hospital. Medicaid regulations specifically require that review of the treatment plan shall be every three months. According to the medical reviewers, although the medical records contained evidence of frequent visits documented in progress notes, the treatment plans were not current for the dates of service reviewed as required. Without an up-to-date, physician-signed, proper treatment plan to identify the patient's diagnosis, problems and strengths, treatment goals, as well as objectives and services necessary to accomplish those goals, we could not determine with any certainty that the services were indeed reasonable and necessary. We believe that no adjustments to our report are necessary for the five claims totaling $690.

Auditee Response Regarding Physician Signatures

The Hospital acknowledged that for the five claims totaling $646, which lacked a physician signature on the current treatment plan, the treatment plans did not contain the required signature. However, the Hospital believed that for two of the claims totaling $243, there was other adequate documentation in the medical record to support ongoing physician involvement in each case. For the remaining three claims, the Hospital merely acknowledged that the treating physician did not sign the treatment plan.

OIG Comments on Physician Signatures

We reviewed the Hospital's response regarding physician signatures on treatment plans. The Hospital believed that the physician's signature on other supporting documentation in the medical record was a sufficient substitute for the missing signature on the treatment plan. We disagree. Medicaid regulations require the signature of the physician involved in the treatment to be included on the treatment plan and the periodic review of the treatment plan, respectively. The medical reviewers noted that although the physician's visits to the patient were documented, the physician did not sign the current treatment plan. Without an up-to-date, physician-signed, proper treatment plan to identify the patient's diagnosis, problems and strengths, treatment goals, as well as objectives and services necessary to accomplish those goals, we could not determine with any certainty that the services were indeed reasonable and necessary. We believe that no adjustments to our report are necessary for the five claims totaling $646.

Auditee Response Regarding Discharge Planning

The Hospital believed that the three claims totaling $266, disallowed for insufficient discharge planning, did in fact contain sufficient evidence that discharge planning had been discussed. The response indicated that the treatment plans did contain minimal comments, but were reasonable expressions under the particular circumstances of those claims that discharge planning had been considered and addressed. For example, the Hospital felt that the notation "N/A" (not applicable) was adequate documentation of discharge planning for a patient not yet diagnosed. The Hospital also believed that the severity of a patient's condition and/or the unresolved status of a patient's diagnosis and prognosis were sufficient documentation of discharge planning.

OIG Comments on Discharge Planning

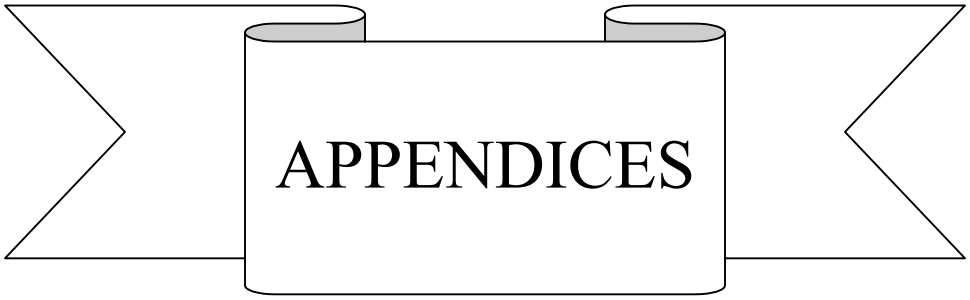
We reviewed the Hospital's response regarding insufficient discharge planning on treatment plans. We disagree. Medicaid regulations require the initial treatment plan to include criteria for discharge planning and periodic reviews of treatment plans to include intervention strategies or initiation of discharge planning, as appropriate. According to the medical reviewers, the fact that a patient's mental condition is chronic addresses the patient's need for continued treatment but not the criteria for discharge. In addition, the medical reviewers stated that the use of "N/A" is not adequate documentation if unable to specify discharge criteria. We believe that no adjustments to our report are necessary for the three claims totaling $266.

Auditee Response Regarding Services Not Supported by Medical Records

The Hospital acknowledged that for the one claim totaling $118, which did not contain documentation supporting the service billed, the progress note was missing from the patient's medical record. However, the response indicated that there was other evidence produced on the same date, and signed by the physician, indicating that the service was in fact provided.

OIG Comments on Services Not Supported by Medical Records

We reviewed the Hospital's response regarding services not supported by the medical records. We disagree. Medicaid regulations require progress notes to be completed by the clinical staff member(s) who provided services. The notes should identify the particular services provided and the changes in goals, objectives and services, as appropriate. Progress notes should be recorded at each visit and/or contact for clinic treatment programs. According to the medical reviewers, no progress note or clinical documentation was provided for the date of service. Without complete medical record documentation, including a description of what took place in a therapy session, the patient's interaction with group members, his/her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the patient's level of care is unclear. We believe that no adjustments to our report are necessary for the one claim totaling $118.


APPENDICES

APPENDIX A

REVIEW OF MEDICAID OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY HILLSIDE HOSPITAL NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM FOR THE YEAR ENDED SEPTEMBER 30, 1999

STATISTICAL SAMPLE INFORMATION

POPULATION	**SAMPLE**
	ERRORS
Items: 64,520 Claims	Items: 100 Claims
	Items: 14 Claims
Claims: $8,490,735	
	Claims: $13,543
	Claims: $1,720

PROJECTION OF SAMPLE RESULTS
Precision at the 90 Percent Confidence Level

Point Estimate: $1,109,550
Lower Limit: $638,260
Upper Limit: $1,580,841

NORTH SHORE - LONG ISLAND JEWISH HEALTH SYSTEM
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Via Fax and Federal Express

Timothy J. Horgan
Regional Inspector General
for Audit Services
Region II
U.S. Department of Health and Human Services
Jacob K. Javits Federal Building
26 Federal Plaza, Rm 3900A
New York, New York 10278

Re: Common Identification Number A-02-00-01023

Dear Mr. Horgan:

This letter is submitted in response to the U.S. Department of Health and Human Services, Office of Inspector General ("OIG") draft audit report dated April 2001 entitled "Review of Medicaid Outpatient Psychiatric Services Provided by Hillside Hospital, North Shore-Long Island Jewish Health System for Fiscal Year Ended September 30, 1999" ("Draft Report").

Hillside Hospital (the "Hospital") is a division of Long Island Jewish Medical Center ("LIJ"), a not-for-profit teaching hospital located on the border of Queens in New York City, and Nassau County on Long Island, New York. The Hospital's main campus is adjacent to LIJ; in addition, in order to assist patients closer to their homes, the Hospital provides mental health and substance abuse treatment services at several community-based clinics in its service area. The Hospital provides treatment programming spanning the full range of the behavior health care continuum, including inpatient treatment, residential services, partial hospitalization, continuing day treatment, day treatment, intensive psychiatric and vocational rehabilitation and ambulatory clinic treatment for children, adolescents, adults and geriatric patients. The Hospital's programs are geared not only to those requiring relatively routine care, but also to the most seriously mentally ill and emotionally disturbed population in its service area, including those who are persistently and chronically ill, those who have failed to respond to conventional treatment and those with special needs, such as the developmentally disabled with acute psychiatric problems. With its seventy-year tradition of excellence and innovation, the Hospital has demonstrated that mental illness can be treated successfully and that people who are ill can, with proper intervention, lead useful, productive lives. It is in keeping with these goals and the Hospital's charitable mission that the Hospital extends charity care services to many poor, seriously and persistently mentally ill patients with complex and complicating social and medical issues. In

addition, during the period 1997 to 2000, more than 35.2% of the Hospital's pediatric patients and 42.5% of the Hospital's adult patients were enrolled in the Medicaid program.

The Hospital appreciates the professionalism and responsiveness of the audit team during the review process. The auditors reviewed 100 claims for the period of October 1, 1998 through September 30, 1999. A number of valuable recommendations were made regarding operational measures that could be taken to enhance and facilitate the Hospital's continued compliance with Medicaid reimbursement regulations. Moreover, the audit team noted that there was no evidence that services were not rendered, and that the services rendered appeared to be warranted as well as necessary.

The Hospital appreciates the general conclusions of the Draft Report that the Hospital received reimbursement for claims that were reasonable, necessary and adequately supported by medical records, and that the Hospital had adequate procedures for proper billing of Medicaid outpatient services.

In addition to these conclusions, however, the Draft Report cited a small minority of claims (13 out of 100) in the audited sample that did not meet the technical requirements for treatment plan documentation, and one claim in which the treatment visit was not properly documented in the medical record. The Draft Report also found limited instances where billing procedures had not been established or where staff did not follow existing procedures. As described more particularly below, in response to the review process and its findings, the Hospital has scrutinized both its medical record-keeping and billing procedures and has implemented changes in order to minimize the type of documentation errors cited in the draft report.

While the Hospital acknowledges that documentation in a few cases was technically incomplete, the Hospital vigorously objects to the nature and severity of the corrective action recommended by the OIG. The claims deemed by the OIG to be unallowable for these reasons amounted to $1,720 (Federal share $860). By extrapolating the ratio of this disallowance to the whole population of Medicaid claims at the Hospital during the audit period, the OIG concluded that the Hospital was overpaid $638,260 (Federal share $319,130). It is the Hospital's position that the repayment recommended by the OIG constitutes a severe penalty, inconsistent with the nature and significance of the auditors' findings.

The Draft Report findings concern noncompliance with specific Medicaid documentation criteria, but do not dispute that the services reviewed were delivered, documented and, in the context of a comprehensive review of overall treatment as documented in the medical records, necessary and reasonable. While the documentation technically did not meet every Medicaid documentation standard, these deviations generally are minor and do not impair a reviewer's ability to determine medical necessity of the services provided. The imposition on the Hospital of liability for the entire extrapolated amount is unduly burdensome without furthering the spirit and purpose of the Medicaid regulations, i.e., to ensure that patients receive only reasonable, necessary and high quality care. Indeed, the magnitude of the proposed disallowance and

recoupment can seriously compromise the Hospital's already limited resources, and thus, its ability to render ambulatory services in the future.

The Draft Report addresses the claims found to have deficient treatment plan review documentation in three categories: lack of current treatment plan, no physician signature, and insufficient discharge planning. This letter addresses those claims in that order, followed by comments on the one case missing a medical record entry for the service rendered. In addition, we summarize the corrective actions implemented, or in process of implementation by the Hospital based upon the auditors' findings. The Hospital is hopeful that the OIG will continue to provide guidance in this area, and also, that the OIG will reconsider its recommendation for repayment based upon the facts and circumstances described below, including, principally, the fact that all of claims submitted were for reasonable, necessary, high quality, and generally well-documented mental health services.

INSUFFICIENT TREATMENT PLANS

The New York State Medicaid regulations, published at Parts 587 and 588 of Title 14 of the Official Compilation of Codes, Rules and Regulations of the State of New York (14 NYCRR) establish certification and reimbursement standards for outpatient mental health programs, including the requirements that a treatment plan be established at the outset of treatment and be reviewed periodically for every patient. The regulations define the essential elements of the initial treatment plan as: (1) the signature of the physician involved in the treatment, (2) the recipient's designated mental illness diagnosis, (3) the recipient's treatment goals, objectives and related services, (4) plan for the provision of additional services to support the recipient outside of the program; and (5) criteria for discharge planning. In addition, the regulations separately define the elements essential to each periodic review of the treatment plan. These are (1) input of all staff involved in the treatment of the recipient; (2) input of the recipient, his or her family and/or other collaterals, as appropriate, (3) assessment of the progress of the recipient in regard to the mutually agreed upon goals in the treatment plan, (4) adjustment goals, time period for achievement, intervention strategies or initiation of discharge planning, as appropriate, and (5) the signature of the physician involved. However, the regulations do not provide for a standard form in which to document the initial treatment plan or the treatment plan reviews.

The state Medicaid regulations also establish time frames for developing the initial treatment plan and for subsequent reviews. Generally, a treatment plan review is due three months after the establishment of the initial treatment plan, and every three months thereafter.

The OIG found that five claims lacked a current treatment plan, five claims had no physician signature on the treatment plan review form, two claims had insufficient discharge planning documentation on the treatment plan or treatment plan review form, and one claim lacked both a physician signature and a sufficient discharge plan. According to the review methodology applied to these claims, the presence of substantive documentation of the treatment planning process in the medical record progress notes was deemed irrelevant if any single element was

found to be missing from the Hospital's treatment plan review form. This "all or nothing" approach resulted in the Draft Report's recommendation of unduly harsh penalties.

Lack of Current Treatment Plan

As described in the Draft Report, treatment planning is the process of developing, evaluating, and revising an individualized course of treatment based upon an assessment of the recipient's diagnosis, behavioral strengths, and weaknesses, problems and service needs. The Hospital engages in treatment planning as a fundamental part of the treatment process, and, in accordance with Medicaid requirements, as an ongoing process carried out by the professional staff in cooperation with the patient and his or her family and other persons, as appropriate. The treatment plan is updated or revised to document changes in the patients condition or needs and the services provided.

The standards of clinical quality embraced at the Hospital incorporate the regulatory requirements for treatment plan reviews at three-month intervals, but also dictate that the treatment plan should be reviewed in an ongoing manner, without waiting for the passage of the prescribed time periods. In fact, treatment is reviewed regularly in a multidisciplinary setting, and these reviews, and recommended changes in the treatment plan, are documented in progress notes in the medical record.

The Hospital acknowledges that in the five cases cited, the Hospital's standard treatment plan or treatment plan review form had been completed more than three months period to the date the claimed-for service was rendered, and therefore, that the technical requirements of the Medicaid regulations may not have been met. Notwithstanding this deficiency, the patients' treatment needs were reviewed regularly by the team of professionals involved in their care, as documented in the medical record progress notes.

In fact, the medical records of three of the cases contain regular "treatment review" notes by the supervising psychiatrist and, taken as a whole, the charts demonstrate that the cases were substantially compliant with the treatment planning requirements.

For example, in the case cited specifically in the Draft Report (claim for services on12/18/98), the treatment plan was noted to be five to six weeks outdated by the date of the service. Accordingly, the auditors deemed the prior treatment plan to be without effect and concluded that there was a "lack of a current treatment plan." Yet in this case of a patient [*], the medical record documents that the patient's physician was actively and frequently involved in the review of the patient's treatment plan. In fact, following the establishment and full documentation of the initial treatment plan on 8/5/98, sections of the progress notes entitled "Treatment Review" were completed and signed by the physician on [*]. In addition, the chart contains frequent comprehensive progress notes by the additional members of the clinical treatment team, including the Certified Social Worker, the Psychiatric Rehabilitation staff and the Psychologist.

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

Claim for Services Provided 7/13/99. Another case presents a particularly compelling example of the Hospital's comprehensive treatment planning, where the physician's delay in signing the designated treatment planning review form is not indicative of the actual treatment planning process documented in other parts of the medical record.

In this case, the auditors correctly determined that the treatment plan review form was not updated within the mandatory three-month interval for the visit billed on 7/13/99. In fact, the existing treatment plan review form was one week out of date: based upon the prior treatment plan review form dated 4/6/99, the next treatment plan review form should have been completed and signed by the physician by 7/6/99.

However, the medical chart provides ample documentary evidence that the treatment plan dated 4/6/99 was appropriately reviewed and monitored by all members of the treatment team throughout the period between 4/6/99 and 7/13/99, the date of service. It documents, among other things, eight physician visits during this three-month period. The physician recommended that the treatment team [*] All of the elements of the treatment plan review, including signed documentation of the physician's input, were accomplished within the time period required for the treatment plan review even though the actual treatment plan review form was not signed by the physician until 8/1/99.

No Physician Signature

The Hospital acknowledges that the treatment plans were not signed by the treating physician in the five cases cited by the Draft Report. However, in two of the five cases there was adequate documentation to support ongoing physician involvement in each case.

Claim for Services Provided 2/24/99. We believe that, notwithstanding the lack of a physician signature on the treatment plan, the auditors had adequate information in the medical record to determine that the there was appropriate documented physician involvement with the patient and clinical team members throughout the treatment plan period. In fact, on the date of service denied by the audit, the physician entered and signed a medication progress note as well as clinical progress notes in the record [*] The hospital argues that the absence of a physician's signature on the treatment plan did not reflect a failure of the physician to provide care and supervision on the case and that the services provided were reasonable and necessary.

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

Treatment Plan for Services Provided 3/29/00. While the hospital acknowledges that the initial treatment form recorded on 3/26/99 was missing a physician's signature, we contend that the medical oversight in this case was appropriate, intensive, and well documented. In addition to documented assessments prior and subsequent to 3/26/99, the physician assessed the patient on the stated date, when appropriate adjustments were made to the patient's medications. A detailed note was entered in the medical record and signed by the physician on that day. All visits with the physician were meticulously documented and signed. The absence of a physician's signature on the treatment plan did not reflect failure of the physician to provide care and supervision on the case, and the physician's notations in the medical chart clearly reflect the clinical assessment of the need for the services provided on 3/29/99.

A number of procedures have been implemented to ensure complete and timely involvement of the physician and the clinical team members in treatment plan reviews and documentation in response to the audit findings. Two of our community-based programs were combined into one location allowing us to streamline the processes involved in the provision of physician coverage at multiple clinical sites without compromising the provision of necessary behavioral health services to our community-based patient population. In addition, a rigorous performance improvement process has been initiated across all of our services to monitor relevant chart documentation, including physician signatures on treatment plans and treatment plan reviews.

Insufficient Discharge Planning

The Draft Report cites three claims for services provided where the current treatment plan did not have a sufficient description of the discharge plan. In these cases, the treatment plan form included comments respecting discharge planning, but the comments were abbreviated and inconclusive, and accordingly, deemed inadequate.

The Hospital believes that to fault the phraseology of the treatment plan writer without viewing the discharge criteria in the context of the entire assessment and treatment of the case seems unduly narrow and critical. The Hospital recognizes that the comments written were minimal, but believes that they were reasonable expressions under the particular circumstances of these cases, demonstrating that discharge planning had been considered and addressed in the treatment planning process. In each of these cases, the medical record documentation taken as a whole demonstrates that at the time the treatment plan was documented, it was extremely unlikely that the patient could anticipate discharge during the treatment plan period based on the severity and/or chronicity of the patient's condition, and, in the latter two cases, the unresolved status of the patient's diagnosis and prognosis. The cases are outlined below.

Claim for Services Provided 10/21/98. In this case, the discharge planning section of the then-current treatment plan review form stated [redacted] *

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

*

Claim for services under treatment plan review dated 9/15/98. The treatment plan review dated 9/15/98 did not specify a discharge plan except to state that the "patient remains symptomatic" and to note that the estimated length of further treatment was "chronic". This notation was deemed by the clinician to be complete because he did not anticipate a discharge in the near future based upon the severity and chronicity of the patient's current symptoms.

This patient was *

The three month treatment plan review standards for clinic treatment programs, as defined in 14 NYCRR 588.6 and 14 NYCRR 587.16(g), require that periodic reviews of the treatment plan address discharge planning "as appropriate". Based upon this stipulation, and in light of the patient's condition and the evolving status of the patient's treatment, the content of the treatment plan review form appears reasonable. In this case, indeed, the clinical staff could not yet identify an appropriate discharge plan, and therefore, the limited comment was considered appropriate.

Claim for services under treatment plan dated 9/23/98. At the initial evaluation *

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

In sum, due to the delays in the evaluation of this patient beyond the control of the Hospital, at the time of the 9/23/98 treatment plan, the patient had not yet been diagnosed and therefore, the outcome of treatment could not be predicted and the criteria for discharge could not yet be determined. The treatment plan form indicates that the estimated total length of treatment would be 20 or more sessions. The criteria for discharge were described as "N/A".

Although the Draft Report would conclude that "N/A" is not a sufficient response, this case clearly demonstrates the futility of an inflexible approach to the treatment plan criteria. Under the circumstances, to identify specific discharge criteria for this very impaired patient would have been so speculative as to be meaningless, and would in no way have contributed to the appropriate utilization of mental health care services or to the quality of care the patient received.

SERVICES NOT SUPPORTED BY MEDICAL RECORDS

The Hospital acknowledges that the progress note for the billed medication management service on 1/19/99 is missing from the patient's medical record. Notwithstanding this omission, there is other clear evidence produced on the same date and signed by the physician, indicating that the service was in fact provided.

In this pediatric case, [redacted]*

[redacted] Although the Medication Progress Note & Flow Sheet cannot be found, Hospital records register the patient as having arrived for his appointment, and a Hillside Hospital Patient Encounter Form was issued for that date to document the medication management service, and the form was signed by the physician. This form documents the delivery of the service billed and was provided to the OIG audit team at the time of the survey.

Under the circumstances, the Hospital cannot agree with the conclusion drawn in the Draft Report that, with respect to future treatment of this patient directed by physicians and therapists, "the lack of required documentation precluded us from determining whether those services were needed."

* Note: We deleted from the response sensitive information on Medicaid beneficiaries and others that the OIG could not release under the Freedom of Information Act.

CORRECTIVE ACTION

We appreciate acknowledgment by the auditors that the Hospital for the most part has adequate procedures for the proper billing of Medicaid outpatient psychiatric services and, consistent with the quality of patient care we strive to provide, that the claims were reasonable, necessary, and adequately supported by the medical records. We take the findings of the audit very seriously and have welcomed the opportunity to review our medical record keeping and billing policies and procedures and have improved a number of processes in an effort to minimize the type of documentation errors identified in the Draft Report.

Policies & Procedures

The draft report indicated that discharge planning was absent from the Hospital policies and procedures manual for the Adult Clinic program. The discharge planning policy is a separate section in the Hospital policies & procedures manual for the Adult Clinic program. If the auditors specifically reviewed the treatment plan policy, they would not have seen a cross-reference to the discharge planning policy located in another section of the manual. A cross- reference to the policy for discharge planning has been incorporated into the body of the treatment plan policy in response to this observation.

The draft also indicated that discharge planning was not included in the initial treatment plan policy of the Hospital policies and procedures manual for the Child Clinic program, although it was incorporated in the treatment plan review. Discharge planning has been added to the initial treatment plan policy in the Hospital policies and procedures manual for the Child Clinic program. A copy of the revised policy is in the process of being distributed to the clinical providers involved in the provision of pediatric behavioral health services.

A letter has been distributed to all behavioral health providers for the adult and pediatric services reiterating the importance of timely and comprehensive documentation of care in the medical record, particularly as related to treatment plans and treatment plan reviews.

Performance Improvement

A comprehensive Performance Improvement Program was instituted 1/1/01 to monitor and audit medical records in addition to other performance indicators for all adult and pediatric psychiatry services. The monthly medical record reviews monitor initial treatment plan and treatment plan reviews for comprehensiveness of clinical information, timeliness, and provider signature in addition to other clinical parameters. The performance improvement reviews provide an opportunity for continuous direct intervention and education of providers concerning medical record documentation requirements.

We are confident that these changes will enhance our efforts to maintain full compliance with all Medicaid billing and documentation requirements.

CONCLUSION

In conclusion, the Hospital remains optimistic that a further review of the cases in question will result in allowance of full payment for the excellent services provided to our patients. Taking back $638,260 is inconsistent with the fact that all of the services for which claims were submitted were reasonable and necessary, and is not in the best interest of our programs or our patients, including the vulnerable Medicaid population in need of high quality mental health care.

Thank you for your consideration of this submission.

Very truly yours,

Nancy Schwartz-Weinstock

cc: John S.T. Gallagher, President & CEO, NS-LIJ Health System
Michael Dowling, Chief Operating Officer, NS- LIJ Health System
Julie Switzer, Esq., Vice President/Deputy General Counsel, NS-LIJ Health System
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